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I have now returned to my office in Melbourne to review your documents and to seek information from any staff members who were part of the medical school faculty during your enrolment. Both the medical course and its staffing have changed considerably since your time here finished in 2009, with a change from the old MBBS program to a North American-style MD in 2011.

I must acknowledge your dissatisfying time with the university, both in what happened and in your experience of the way it was handled. I am sorry that it has had such a negative impact on you and that it continues to cause you distress ten years later. Clearly, you have been deeply upset.

You have laid out what happened in considerable detail. My reading of the documentation you have provided has surprised me in some areas, such as a flat score of 60% being used as a pass mark for each OSCE station. While I don't know what approaches were used back then, we now use psychometrically-based standard setting techniques that more sensitively derive a 'cut score' for each station that defines the minimum level of performance required to demonstrate competence in that skill. It's no help to you, but I'm pleased we are using this method now as a demonstration of the minimum standard required.

I'm sorry that the way OSCE marking sheets are constructed was not better explained to you at the time. You are quite right that there are no marks awarded for auscultation at the antecubital fossa – this is a given and is not worthy of reward. The OSCE process is that marks are only allocated to points of technique that may vary between candidates and have an impact on the patient outcome, such as applying the cuff in the wrong position (eg with the bladder too posteriorly rather than centred over the brachial artery) or deflating it at the wrong speed. Other actions such as placing the stethoscope's diaphragm over the antecubital fossa or removing the cuff at the end are not good discriminators and do not warrant marks. Mind you, if they did not occur the examiner would give minimal marks in the overall technique section. Similarly, the accuracy of the actual blood pressure reading obtained by the student did not contribute to the structured marking rubric for this exam station as it would be unreliable from candidate to candidate. These points should have been explained to you in 2009.

It appears from the marksheet you've provided that the examiner did not award marks for applying the cuff in the correct position, by which I can only presume the bladder was not properly centred over the brachial artery or was too close to the elbow. Also, there were no marks awarded for estimating the systolic blood pressure by palpation. As explained above, there were no marks available for estimating it by auscultation, as this is a poor discriminator of performance. The technique the examiner needed to see was the palpation of the radial pulse to determine the correct level for cuff inflation.

Similarly, when examining the feet there are some actions that carry marks and others that do not. It's important in diabetic management that visual inspection, palpation of peripheral pulses and testing of sensation all take place. It's not clear which techniques you correctly performed in examining the patient's lower limbs

that earned you 4 marks (apart from 'adequate inspection' earning two of the four). I note that the examiner gave you marks for the responses you gave to the questions at the end of the examination, despite your pulse palpation and sensory testing techniques having scored poorly. This is sometimes a problem with the 'check box' nature of older OSCE exams, with points being given for the provision of the correct information even when erroneously derived.

I've reviewed the other OSCE score sheets you have provided and I cannot see any errors there, although the passage of time means that we now have different guides and rubrics. I note your reference in one document to the instructions on the door to the venepuncture station telling you that the patient had anaemia as 'sign-posting' you to skip over a full blood examination as the initial investigation. In fact, 'sign-posting' is a communication skill taught to our students that gives the patient some indication of the direction in which the interview is going and why. The first investigation in a patient with anaemia would be a full blood examination so that the red cell parameters could steer the clinician to further investigations such as iron studies, vitamin B12 assay, haemoglobin electrophoresis et cetera. I'm sorry that terminology was left as a point of confusion for you during the 'Introduction to Clinical Medicine' course.

A change to a student's marks once they have been ratified by the Board of Examiners for a subject requires the approval of the Academic Board. While I cannot find any evidence of errors in the assessment of your performance in the discontinued subject that comprised Semester 9 of the now-defunct MBBS course, I understand that you are entitled to make a formal appeal against the original assessment decision. Although much time has passed, I think the most appropriate process for appeal, should you wish to, is laid out at:

https://about.unimelb.edu.au/strategy/governance/peak-bodies-structures/academic-board/student-appeals/unsatisfactory-progress-appeals

I do understand that your experience in 2008 has left you with a very bad opinion of the university and disappointment with what happened, despite your career successes since. I'm sorry that this was your experience and – as a fellow stutterer – I'd be appalled if that characteristic played a significant part in decisions that were made. As far as I can see, a significant number of OSCE marks were deducted on the basis of knowledge and practical technique rather than any communication difficulties. Similarly, the concept of bullying is deeply abhorrent to all in the Melbourne Medical School and we must respond seriously to all complaints.

I would be very happy to meet you to discuss these points and to offer a personal apology for your experience if you were to ever come to Melbourne through your work. Alternatively, we could find a mutually convenient time for a Zoom or Skype conversation after I return from Jakarta in two weeks.

I hope this apology brings you some closure on what was clearly a distressing phase of your life and I regret the part the medical course played in that. From what I have read about you, your (admittedly expensive) detour into clinical medicine has not hampered your research career.

Yours faithfully

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